Health Information and Quality Authority
Social Services Inspectorate

Compliance Monitoring Inspection Report
Designated Centres under Health Act 2007

Centre name:	Owen Riff Nursing Home
Centre ID:	0375
Centre address:	Camp Street Oughterard County Galway
Telephone number:	091 866946
Email address:	N/A
Type of centre:	☐ **Private** ☐ **Voluntary** ☒ **Public**
Registered provider:	Health Service Executive
Person authorised to act on behalf of the provider:	Catherine Cunningham
Person in charge:	Rose O'Connor
Date of inspection:	25 and 26 September 2012
Time inspection took place:	**Day-1 Start:** 08:30 hrs **Completion:** 17:20 hrs **Day-2 Start:** 08:30 hrs **Completion:** 16:00 hrs
Lead inspector:	Nan Savage
Support inspector(s):	N/A
Purpose of this inspection visit:	☐ to inform a registration/renewal decision ☒ to monitor ongoing regulatory compliance ☐ following an application to vary conditions ☐ following a notification ☐ following information received
Type of inspection	☐ **announced** ☒ **unannounced**

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by Regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of their registration.

Monitoring inspections take place to assess continuing compliance with the Regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Social Services Inspectorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Summary of compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

This inspection report sets out the findings of a monitoring inspection, in which 10 of the 18 outcomes were inspected against. The purpose of the inspection was:

- ☐ to inform a registration decision
- ☐ to inform a registration renewal decision
- ☒ to monitor ongoing compliance with regulations and standards
- ☐ following an application to vary registration conditions
- ☐ following a notification of a significant incident or event
- ☐ following a notification of a change in person in charge
- ☐ following information received in relation to a concern/complaint

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 1: Statement of Purpose	☒
Outcome 2: Contract for the Provision of Services	☐
Outcome 3: Suitable Person in Charge	☒
Outcome 4: Records and documentation to be kept at a designated centres	☐
Outcome 5: Absence of the person in charge	☐
Outcome 6: Safeguarding and Safety	☒
Outcome 7: Health and Safety and Risk Management	☒
Outcome 8: Medication Management	☒
Outcome 9: Notification of Incidents	☒
Outcome 10: Reviewing and improving the quality and safety of care	☐
Outcome 11: Health and Social Care Needs	☒
Outcome 12: Safe and Suitable Premises	☐
Outcome 13: Complaints procedures	☐
Outcome 14: End of Life Care	☒
Outcome 15: Food and Nutrition	☒
Outcome 16: Residents' Rights, Dignity and Consultation	☐
Outcome 17: Residents' clothing and personal property and possessions	☐
Outcome 18: Suitable Staffing	☒

On 27 April 2012, due to the serious issues identified through monitoring and inspection, and pursuant to Sections 59 and 60 of the Health Act, 2007, an ex parte interim order was made by Galway District Court, inter alia, cancelling the registration of Owen Riff Nursing Home, Camp Street, Oughterard, County Galway as a designated centre under Part 8 of the Health Act 2007. In accordance with Section 64 of the Health Act, 2007, the Health Service Executive (HSE) was directed by the District Court to make alternative arrangements for the residents of Owen Riff Nursing Home as soon as practicable.

On 4 July 2012, Galway District Court determined the matters dealt with in the ex parte interim order of 27 April 2012 and confirmed that the ex parte interim order which, among other things, cancelled the registration of Owen Riff Nursing Home.

In accordance with Section 64 of the Health Act 2007, the HSE had been, pursuant to the order of the District Court, the provider at Owen Riff Nursing Home since 27 April 2012.

This monitoring inspection was unannounced and took place over two days on 25 and 26 September 2012. As part of the monitoring inspection, the inspector met with residents and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

Overall, residents' healthcare needs were being well met. In response to the health needs of residents, the person in charge had established evidence-based nursing practices in nutritional management and wound care management and had supported nursing and care staff to implement practices in these areas. Residents had access to a range of allied health professionals, and general practitioners (GPs) carried out regular medical reviews of residents.

However, the inspector was significantly concerned that the health and safety of all residents had not been safeguarded. These concerns related to the safety of some immobile residents in the event of an emergency evacuation from the centre, the absence of an emergency plan, the inappropriate use of metal bedrails and inadequate precautions taken to protect residents from abuse. Because of these risks, the inspector informed the person in charge that immediate action was required to address these issues. This was followed up with a telephone call to the provider on 27 September 2012 and the issuing of a written immediate action plan by the Authority on 28 September 2012. Due to the risks identified, the Acting Chief Inspector took the critical step in setting the timeframes by which the provider had to address these failings. The initial information submitted by the provider did not give sufficient reassurance that the areas of concern had been adequately addressed and the provider was required to submit further information which was satisfactory.

The inspector found that governance arrangements within the centre were poor. Residents' finances were not being overseen by the provider and the provider had not put any formal arrangements in place to ensure that the interests of residents were being protected. The person in charge did not have sufficient control over the staffing arrangements or the staff roster and some staff that worked in the centre were not adequately supervised. Improvements were also required to the upkeep of some parts of the premises and maintenance of equipment. Some required documentation was not made available for inspection and monitoring purposes.

Section 41(1)(c) of the Health Act 2007

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Theme: Governance, Leadership and Management

Effective governance, leadership and management, in keeping with the size and complexity of the service, are fundamental prerequisites for the sustainable delivery of safe, effective person-centred care and support.

Outcome 1

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

References:

Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Inspection findings

The statement of purpose dated 26 September 2012 was in draft format. The inspector noted that while it complied with most requirements, some improvements were required to fully meet the Regulations. For example, the complaints procedure that was described in the statement of purpose was not in compliance with the Regulations.

Also, the inspector found that the fire procedures and associated emergency procedures were not sufficiently detailed. In addition, the arrangements made for the supervision of specific therapeutic techniques used in the centre was not documented.

Theme: Safe care and support

Safe care and support recognises that the safety of service users is paramount. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers.
In a safe service, a focus on quality and safety improvement becomes part of a service-wide culture and is embedded in the service's daily practices and processes rather than being viewed or undertaken as a separate activity.
To achieve a culture of quality and safety everyone in the service has a responsibility to identify and manage risk and use evidence-based decision-making to maximise the safety outcomes for service users.

Outcome 6

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

References:
Regulation 6: General Welfare and Protection
Standard 8: Protection
Standard 9: The Resident's Finances

Inspection findings
Sufficient measures were not in place to protect residents being harmed or suffering abuse.

The inspector was very concerned that an allegation of abuse had not been investigated and that the Acting Chief Inspector had not been notified of this incident, as required in the Regulations. The provider was issued an immediate action to address this concern and requested to submit a report outlining the investigation findings.

The inspector noted that this allegation of abuse had been recorded on a complaint form maintained in the complaints folder. The person in charge stated that she was not aware of this incident which had occurred on 31 August 2012 and did not know what member of staff the allegation had been made against. The inspector read that 'pending' had been recorded under the 'immediate action taken' section of the form but there had been no investigation carried out into this allegation.

There was no policy on preventing abuse and responding to allegations or suspicions of abuse. While staff spoken with were familiar with the different types of abuse, some were not clear on how to respond to suspicions of abuse. Some staff members stated that the decision to report the alleged abuse depended on how serious they thought it was. These staff members had not received adequate education on the prevention, detection and response to elder abuse.

The inspector was concerned that the provider did not manage residents' finances and did not have formal arrangements in place to protect the interests of residents. The person in charge reported that she had no control over residents' finances and did not have access to them. The inspector noted that sufficient information was not being recorded in relation to residents' personal monies including the date on which money was received and details of when money was returned to residents.

Outcome 7
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Inspection findings

The provider had systems in place to protect the health and safety of residents, staff and visitors but aspects were not adequate and required significant improvement. The inspector identified some hazards that posed a risk of harm to residents and others.

An emergency plan was not in place to guide staff in the event of emergencies such as flooding and loss of power or heat. The provider was required to take immediate action in relation to this risk and a written immediate action plan was issued to the provider on 28 September 2012.

While specific fire safety precautions were in place these measures were not sufficient to promote and protect the safety of all residents.

The inspector was very concerned that a safe evacuation plan had not been developed for some immobile residents. Staff told the inspector that evacuation sheets were part of the evacuation plan for immobile residents. However, the inspector noted on day-one that some immobile residents requiring evacuation with the use of an evacuation sheet did not have these sheets on their beds. This was brought to the immediate attention of the person in charge. On day-two of the inspection, the person in charge had decided to transfer two of these residents to the ground floor. She stated that the manager for older people services with the HSE had been informed and that evacuation sheets were being delivered to the centre. At the end of the inspection these sheets had not arrived. The provider was also required to take immediate action in relation to this risk.

Some fire escape routes were not keep fully clear and were partially obstructed with flammable materials such as a trolley containing bags of laundry and a specialised wheelchair containing exposed foam. This was brought to the attention of the person in charge during the inspection.

An independent fire safety compliance survey report dated 23 May 2012 had identified a number of risks and subsequent recommendations including the provision of evacuation sheets for immobile residents. However, there was no evidence to confirm that the provider had put a plan in place to address the risks identified in this report.

A risk management policy was in place dated February 2012 which included a statement of intent signed by the person in charge. However, there was no health and safety statement signed by the provider. A risk management folder was available and contained risk assessments that had been completed for specific risks which could occur in the centre. However, some assessments and procedures did not fully reflect practices in the centre and there were no risk assessments available for parts of the centre including the laundry room, communal and outdoor areas. Also, the policy did not cover specific risks required by the Regulations including self harm, assault and the arrangements for the identification, recording, investigation and learning from serious incidents.

The inspector identified a number of environmental risks during the inspection which posed a risk to residents' safety and which were not being managed by the provider. For example:

- doors within the centre had a key-pad locking system. However, the inspector noted that on occasions a door from the ground floor to the first floor was not secure and provided direct access onto the stairs which was a risk to the safety of residents who walked and who were at risk of falling
- the doors to the ground floor sluice room and laundry room were left open. They were unattended at the time and so posed a risk to residents.

The inspector was also concerned that infection control measures within the centre were not robust. Issues identified, but not limited to, included:

- the water temperature from the hot water tap at the ground floor residents' toilet was cold
- the dishwasher was not working at the required temperature to safely sterilise delph and cutlery
- there was no clinical waste bin in the room of a resident with Methicillin-resistant *Staphylococcus aureus* (MRSA)
- there was no area for segregating clean and soiled clothing. Bags of soiled laundry were left open in the laundry room in close proximity to clean laundry. This room was also used to store and wash cleaning equipment.

The inspector found that other specific fire safety precautions were in place. Fire extinguishers were serviced in April 2012 and quarterly servicing of the fire alarms had been carried out in March and June 2012. The person in charge completed a weekly fire inspection and stated that this included checking the fire panel and fire extinguishers. Adequate controls were in place to monitor all visitors to the premises. The inspector noted that a record of visitors to the centre was completed daily in a visitors' book located at the entrance.

Staff on duty had received mandatory training in moving and handling within the last three years and this was confirmed by speaking with staff and viewing training records. The inspector also noted that measures were in place to reduce accidents and promote residents' mobility within the centre including safe floor covering and handrails. In addition, call bells were found within easy reach of residents and residents spoken with were satisfied that call bells were responded to promptly.

Outcome 8
Each resident is protected by the designated centres' policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Inspection findings
The inspector reviewed the policy on medication management which was dated March 2010. While the policy was not centre-specific, it provided direction to nurses on the safe management of medication. Generally, the inspector found good practice

in the management of medication but improvements were required to the prescribing of as required medication (PRN) and the prescription sheet. Also, there was no procedure for the disposal of medication.

The inspector observed nursing staff on a medication round and found that, overall medications were administered in accordance with professional guidelines. However, the maximum dosage for PRN (as required) medication was not recorded on the residents' prescription sheets. The medication management policy stated that the prescription should state the maximum dose in a 24-hour period for PRN medication. Also, residents' prescription sheets did not contain information including the resident's date of birth and address, as required by the medication policy.

Arrangements for medication that required strict controls (MDAs) were reviewed. These medications were being stored in a locked cupboard within a locked cupboard and were found to be secure. The medications were being recorded in a Controlled Drug Register and the balances were being documented at the change of each shift by two nurses. The inspector viewed the balances of medication for three residents and found that the entries in the Controlled Drug Register were correct.

While good practices were noted in the storage and disposal of medication, there was no policy on the disposal of medication. The inspector noted that a pharmacy return book was maintained which included details of all medications returned to the pharmacy. The returned medications were signed by both a nurse and the pharmacist. The inspector checked a sample of medications and found that they were in date. Also, the medication fridge was stored in the clinical room which was kept locked at all times when not in use.

Outcome 9
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems
Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Inspection findings
The inspector reviewed accident and incident records and the practice in relation to notifications of incidents.

As discussed earlier in Outcome 6, the person in charge had failed to notify the Acting Chief Inspector about an allegation of abuse in the centre.

Information was recorded for other incidents and accidents that had occurred in the centre including what had happened and the actions that were taken. However, the inspector noted the preventative action identified for a resident who had experienced some falls had not been used to inform the resident's care plan.

Theme: Effective care and support
The fundamental principle of effective care and support is that it consistently delivers the best achievable outcomes for people using a service within the context of that service and resources available to it. This is achieved by using best available national and international evidence and ongoing evaluation of service-user outcomes to determine the effectiveness of the design and delivery of care and support. How this care and support is designed and delivered should meet service users' assessed needs in a timely manner, while balancing the needs of other service users.

Outcome 11
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

References:
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan
Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Inspection findings
Residents had good access to general practitioner (GP) services and to an out-of-hours GP service. The inspector also saw evidence that residents could access a range of other health professionals if they required. Inspectors saw assessments and notes of reviews by dietetics, speech and language therapy (SALT), tissue viability and mental health services. In addition, residents attended physiotherapy and some residents had been referred to an occupational therapist (OT).

Generally, the inspector found that the healthcare needs of residents were being well met. The person in charge had introduced evidence-based nursing practices in response to the health needs of residents in areas such as nutritional management and wound care. The inspector found that there had been significant improvements in these areas since the previous inspection.

However, the inspector was very concerned that there was no process in place for checking metal bedrails and noted that some bedrails were very loose and posed a risk to residents' safety. This was brought to the immediate attention of the person in charge. An immediate action plan relating to this risk was issued to the person in charge on day-two of the inspection and followed up in writing to the provider on 28 September 2012.

Other significant issues were also identified in relation to the management of the use of restraint and included:

- a high number of residents were using metal bedrails. The inspector reviewed a sample of residents' files and found that one resident with bedrails in use had not been assessed for the use of the bedrails
- some assessments were not completed correctly. For example, one assessment stated that there were no gaps between the bedrail and resident's bed. However, gaps were noted and short bumpers were also in use which increased the risk of entrapment
- some residents who had bedrails in situ did not have care plans in place to guide staff on the management of the use of the bedrails
- there was no evidence on some residents' files to demonstrate that alternatives to the use of restraint had been tried
- the duration of the use of restraint was not recorded for residents using bedrails
- the policy on the use of restraint was not centre-specific and did not adequately inform practice.

The inspector reviewed a sample of care plans that had been implemented by the person in charge. Residents were assessed using validated assessment tools for a range of health needs including falls risk, manual handling, nutrition, continence management, pressure care and dependency. The care plans reviewed were written in an individualised and respectful manner. Care plans were developed for identified needs and most provided sufficient guidelines to staff on meeting the needs of residents. However, improvements were required. In some residents' files there was no comprehensive nursing assessment while in others this assessment had not been maintained up to date. While a number of care plans had been reviewed three-monthly, some had not been updated to reflect the changing needs of residents. Also, there was no evidence that the views of residents or their representatives had not been sought during the development and review of care plans.

The inspector reviewed a number of healthcare areas which had been identified as requiring improvement in previous inspections.

The person in charge had reviewed the processes for managing the risk of wounds and responding to wounds. The inspector reviewed the assessments and care plans for a sample of residents who had wounds and residents who had wounds which had healed. The assessments were detailed and informed the care delivery. The wounds were monitored regularly and a detailed record of the progress of healing was maintained. Nurses spoken with were knowledgeable of residents who had wounds and the measures in place to treat the wounds. Nurses were including a consideration of other related health issues such as nutrition when developing care plans for managing wounds. The person in charge had completed a risk assessment

for wounds and identified a number of controls required to prevent and respond to wounds. These controls were evident in practice.

A comprehensive system had been put in place to monitor residents' nutritional status and as a result, the inspector found evidence of good practice in this area. The nutrition status of all residents was being assessed on a three monthly basis or more often if required. Residents' weights were being monitored monthly so that staff could respond to any issues in a timely manner and three-day food and fluid intake charts were been recorded when required. Any residents who had experienced weight loss had been weighed on a weekly basis and had their assessment and care plan reviewed. The chef on duty had been provided with up-to-date information sheets on the food requirements of residents who had been assessed at risk or who had been reviewed by the dietician. The inspector spoke with the dietician during the inspection who commented that residents' weights were now being very well monitored by staff. However, the centre's policy on nutrition management was generic and had not been adapted to provide specific guidelines for the management of nutrition in the centre.

The inspector was informed that there was currently one resident in the centre with challenging behaviour. The inspector found that staff were consistent when describing how they responded to this resident's behaviour and identified specific triggers and techniques that they used to prevent escalation of the behaviour. The inspector viewed the resident's care plan and found that the resident required additional support and had been referred to the mental health team who provided assessment and recommendations on the resident's care. The care plans for this resident reflected most recommendations of health professionals and included sufficient guidelines on preventing incidents.

However, there were some areas for improvement. While the resident's care plan provided guidelines to staff on preventing incidents, it did not provide sufficient guidelines to staff on how to respond appropriately to incidents when they did occur. Also, the policy on behaviour management was not centre-specific and had not yet been adapted to reflect local arrangements.

The inspector viewed a sample of assessments and care plans of residents who had had recent falls and found that some assessments and associated care plans had not been reviewed after each fall. As referred to in Outcome 9, one resident's care plan did not include a falls preventative action that had been identified after this resident had a fall. Also, two falls assessments were in use which resulted in different assessment ratings for one resident who was identified at risk of falling. While measures had been put in place to prevent falls, the inspector found that some care plans contained generic interventions which did not adequately guide staff practice.

The inspector found that during day-one of the inspection there were limited activities and meaningful events for residents to participate in. During the late morning the inspector noted six residents sitting in the day room, some of whom were asleep while others watched television. Planned activities for that afternoon were cancelled because the activities coordinator was not on duty. The inspector noted that recreational care plans were in place for residents and while they were not based on a social assessment, these care plans had been informed by residents'

interests and activity preferences. However, there was limited evidence during the inspection that this information had been used to sufficiently inform residents' social care.

The inspector found that during parts of the inspection, staff – including the person in charge – visited the day room and interacted with residents in a sensitive and appropriate manner. On day two of the inspection, the inspector noted that activities including bingo took place in the day room and residents who participated appeared to enjoy this activity.

Outcome 12
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Inspection findings
The inspector specifically reviewed measures that were in place for the upkeep of the premises and equipment.

The inspector found that some parts of the centre were not maintained in a clean and hygienic condition. For example, there was a build up of dust and grime on the skirting boards in some residents' en suite bathrooms and in the staff/visitors' toilet at the reception area. There was also a strong musty smell in the reception area which emanated from the staff/visitors' toilet located in this vicinity. The inspector noted that the ventilation in the lobby area to this toilet was not adequate.

The inspector found that some equipment was not maintained in good working order. The bedpan washer located in the ground floor sluice room was broken at the time of inspection. Also mop heads in use were very frayed. The inspector read that the person in charge had obtained a quotation in July 2012 for a single use mop-head system but the inspector was told that the purchase of this cleaning equipment had not been authorised.

The temperature of the water supplied at wash-hand basins was not properly regulated. Thermostatic control values or other suitable anti-scalding devices had not been fitted to wash-hand basins, as required in the Regulations.

There was inadequate storage for assistive equipment. This resulted in wheelchairs being stored under the stairs in the front area of the building.

Some required documentation was not made available for inspection and monitoring purposes in accordance with the requirements of the Health Act 2007. The inspector was unable to review servicing and maintenance records for some appliances and assistive equipment which were in use including transit wheelchairs, pressure

relieving mattresses and metal bedrails. The inspector noted that the person in charge kept a maintenance book at the reception area for staff to record small items that required repair.

Theme: Person-centred care and support
Person-centred care and support has service users at the centre of all that the service does. It does this by advocating for the needs of service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care. Person-centred care and support promotes kindness, consideration and respect for service users' dignity, privacy and autonomy.

Outcome 14
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

References:
Regulation 14: End of Life Care
Standard 16: End of Life Care

Inspection findings
Sufficient measures were not in place to support and meet the care needs of residents at end of life.

There was an end-of-life policy dated April 2011 but this was in draft format and not centre-specific. The inspector found that residents did not have an end-of-life care plan in place including a resident that the person in charge identified as approaching end of life. The person in charge reported that arrangements were in place for support from the local hospice team, if required.

Outcome 15
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

References:
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Inspection findings
The inspector found that residents had access to food and drinks when required and in a manner that met their needs. Drinks were available throughout the day.
The inspector observed the main lunch time meal. Residents had a choice of meals and a variety of portions sizes were served depending on the resident's needs and wishes. Staff provided assistance to some residents who required support in a respectful manner, and encouraged social interaction during the meal.

Some residents had specific dietary requirements. Modified consistency meals were nicely presented with ingredients pureed separately and they looked appetising. The chef had up-to-date information on the dietary requirements of residents, including information on enhancing the nutritional value of food and providing appropriate meals for residents with specific conditions such as diabetes.

The inspector visited the kitchen and found that it was maintained in a clean condition. There was a sufficient supply of fresh and frozen foods.

Outcome 17
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

References:
Regulation 7: Residents' Personal Property and Possessions
Regulation 13: Clothing
Standard 4: Privacy and Dignity
Standard 17: Autonomy and Independence

Inspection findings
There was a policy on residents' personal property and possessions but this policy was not centre-specific and did not inform practice. Adequate space was provided for residents' personal possessions. However, the inspector noted that up-to-date lists of residents' personal property were not maintained.

Theme: Workforce
The workforce providing a health and social care and support service consists of all the people who work in, for, or with the service provider and they are all integral to the delivery of a high quality, person-centred and safe service. Service providers must be able to assure the public, service users and their workforce that everyone working in the service is contributing to a high quality safe service.

Outcome 18
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

References:
Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications
Standard 24: Training and Supervision

Inspection findings

While there appeared to be adequate staff levels and skill mix, the inspector was concerned that the staffing arrangements did not ensure the safety and wellbeing of residents. Also, the inspector requested confirmation of the dependency levels of residents but this information was not made available.

The provider had failed to implement adequate recruitment, selection and vetting procedures. The inspector reviewed the arrangements for staff management and discussed these with the person in charge and other staff members. The current provider had not ensured that the person in charge had control over staffing to ensure that sufficient numbers of staff and skill mix were available at all times to meet residents' needs. The reporting arrangements for staff were not clear and the person in charge did not have management control of staffing. Not all staff were in the employment of the provider. The inspector observed that some staff hours were being changed without the prior knowledge of the person in charge.

The policy on the recruitment, selection and vetting of staff was not centre-specific and did not adequately inform practice. The inspector viewed a sample of staff files and found that they contained the majority of required information. However, some information required by the Regulations had not been obtained for all staff. For example, some staff files did not contain sufficient evidence of the employee's mental and physical fitness. Also, evidence was not available to confirm that Garda Síochána vetting had been obtained for all staff.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the person in charge and a number of staff to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

Nan Savage

Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

28 September 2012

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report *

Centre Name:	Owen Riff Nursing Home
Centre ID:	0375
Date of inspection:	25 and 26 September 2012
Date of response:	14 November 2012

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Theme: Governance, Leadership and Management

Outcome 1: Statement of purpose and quality management

The provider is failing to comply with a regulatory requirement in the following respect:

The statement of purpose did not meet all of the requirements in Schedule 1 of the Regulations.

Action required:

Compile a statement of purpose that consists of all matters listed in Schedule 1 of the Regulations.

Reference:

Health Act, 2007
Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

* The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: This response was sent to the Authority previously on 2 October 2012	Completed

Outcome 4: Records and documentation to be kept at a designated centre

The person in charge is failing to comply with a regulatory requirement in the following respect:

Adequate systems were not in place to manage residents' finances. Also some records and documents were not available during the inspection.

Action required:

A record of all money or other valuables deposited by a resident for safekeeping or received on the resident's behalf, which shall state the date on which the money or valuables were deposited or received, the date on which any money or valuables were returned to a resident or used, at the request of the resident, on their behalf and, where applicable, the purpose for which the money or valuables were used; and shall include the written acknowledgement of the return of the money or valuables.

Action required:

Make the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) of the Regulations available at all times for inspection and monitoring purposes under the Act.

Action required:

Maintain the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) of the Regulations in a manner so to ensure completeness, accuracy and ease of retrieval.

Reference:

Health Act, 2007
Regulation 22: Maintenance of Records
Standard 32: Register and Residents' Records

Please state the actions you have taken or are planning to take with timescales:	Timescale:

Provider's response: Maintenance payments are made in respect of three patient types. HSE has submitted financial records in respect of all residents separately to the Authority.	Completed

The provider is failing to comply with a regulatory requirement in the following respect: While policies were available in the centre, they had not been put in place and did not provide guidance to staff on practices in the centre.	
Action required: Put in place all of the written and operational policies listed in Schedule 5 of the Regulations.	
Reference: Health Act, 2007 Regulation 27: Operating Policies and Procedures Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We have edited all policies listed in Schedule 5 of the Regulations to make them centre-specific. We expect this process to finish in November and have scheduled staff meetings to implement same.	November 2012

Theme: Safe care and support

Outcome 6: Safeguarding and safety

The provider is failing to comply with a regulatory requirement in the following respect: Adequate safeguarding arrangements were not in place to protect residents from being harmed or suffering abuse. There was no policy on elder abuse, some staff had not received education on elder abuse and when spoken with were unsure of their responsibilities in reporting suspected elder abuse. The inspector read that there had been an allegation of abuse on 31 August 2012 but this had not been investigated and the person in charge stated that she was not aware of this allegation.

A written immediate action was issued in relation to this failing.
Action required: Put in place all reasonable measures to protect each resident from all forms of abuse.
Action required: Put in place a policy on and procedures for the prevention, detection and response to abuse.
Action required: Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.
Action required: Take appropriate action where a resident is harmed or suffers abuse.
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 8: Protection

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We have a range of measures in place to prevent, detect and deal with elder abuse. Staff work where necessary in pairs. A centre-specific policiy and procedure is in place and implemented. Instructions on the correct use of equipment are displayed in the unit. Training associated with policy and procedures was provided to all staff on 8 and 17 October 2012.	Completed

Outcome 7: Health and safety and risk management

The provider has failed to comply with a regulatory requirement in the following respect: The provider had identified the arrangements for the evacuation of residents and these included the use of evacuation sheets for immobile residents. Some immobile residents requiring evacuation with the use of an evacuation sheet did not have evacuation sheets on their beds. A written immediate action was issued in relation to this failing.

Two emergency exit routes were partially obstructed during the inspection.

Action required:

Make adequate arrangements for the evacuation, in the event of fire, of all people in the designated centre and the safe placement of residents.

Action required:

Provide adequate means of escape in the event of fire.

Reference:

Health Act, 2007
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: An Emergency policy and procedures was sent to the Authority on 2 October 2012. All beds have an evacuation sheet. All exits are free of any obstacles and signs are displayed to alert staff to keep exits free.	Completed

The provider is failing to comply with a regulatory requirement in the following respect:

Deficits were identified in the management of risk in the centre. For example:

- there was no emergency plan in place
- the inspector identified some environmental and infection control hazards which did not have a risk management plan and which posed a risk to residents' safety
- all areas of the centre had not been risk assessed and associated controls had not been put in place
- some identified controls to manage a specific risk posed by a resident smoking in a bedroom had not been implemented
- the risk management policy did not adequately cover specific risks including self-harm and assault, and the arrangements for the recording and learning from serious or untoward incidents.

A written immediate action was issued in relation to the absence of an emergency plan.

Action required:

Put in place an emergency plan for responding to emergencies.

Action required:

Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

Action required:

Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

Action required:

Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.

Reference:

Health Act, 2007
Regulation 31: Risk Management Procedures
Standard 26: Health and Safety
Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: We are in the process of editing the risk management policy regarding clinical risks. Risk Management regarding staff is dealt with in the Owen Riff Safety Statement. All reasonable measures are in place to minimise risk in Owen Riff. The grounds were tidied, rubbish was removed and a seating area was created for use of the residents and family. Hazard signs are in place to warn residents, family and staff when floors are cleaned, call bells are in place, care is provided by one or two members of staff where indicated, and individual risk assessments re: clinical risk are stored in the residents care files.	November 2012

The Administrator is now situated at a new reception desk to enhance supervision of the entrance. All reasonable measures are in place to prevent accidents to residents, family and/or staff. The risk management policy refers to the separate policies and procedures regarding unexplained absence of a resident, assault/aggression and violence, accidental injury and self-harm.	

Outcome 8: Medication management

The provider and person in charge are failing to comply with a regulatory requirement in the following respect:

The medication management policy was not centre- specific and there was no procedure for the disposal of medication.

Nurses were administering medication without sufficient information available on the prescriptions such the maximum dose of PRN (as required) medication in any 24-hour period and the resident's date of birth.

Action required:

Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

Action required:

Put in place suitable arrangements and appropriate procedures and written policies in accordance with current Regulations, guidelines and legislation for the handling and disposal of unused or out-of-date medicines and ensure staff are familiar with such procedures and policies.

Action required:

Complete, and maintain in a safe and accessible place, an adequate nursing record of each resident's health and condition and treatment given, on a daily basis, signed and dated by the nurse on duty in accordance with any relevant professional guidelines.

Reference:

Health Act, 2007
Regulation 25: Medical Records
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 13: Healthcare
Standard 14: Medication Management
Standard 15: Medication Monitoring and Review

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The policies and procedure for ordering, prescribing, storing and administration of medicines to residents are in place, edited to reflect the situation in Owen Riff. Nurses are no longer administering PRN (as required) medication without sufficient information available regarding the maximum dose over 24-hour period. A policy and procedure on the handling, disposal of unused or out-of-date medicines is in place and implemented. See attached.	Completed

Theme: Effective care and support

Outcome 11: Health and social care needs

The provider has failed to comply with a regulatory requirement in the following respect: Significant shortcomings were identified in the management of the use of restraint.
Action required: Put in place suitable and sufficient care to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs.
Action required: Provide a high standard of evidence-based nursing practice.
Reference: Health Act, 2007 Regulation 6: General Welfare and Protection Standard 13: Healthcare Standard 18: Routines and Expectation

Please state the actions you have taken or are planning to take with timescales:	Timescale
Provider's response: There is a reduction in the use of bedrails in the centre. Risk assessments are in place for those residents that still have bedrails attached to his/her bed for special awareness or supporting a resident to reposition him/herself.	Completed

Periodical assessments/audits results give indications of high standard of care in the centre – quality indicators are used to achieve same.	Completed for October and ongoing

The person in charge is failing to comply with a regulatory requirement in the following respect: Some issues were identified in the care planning process and some improvements were required to the care planning documentation in the management of falls and behaviour that challenges. Residents and/or their representative were involved in the development and review of the resident's care plan.	
Action required: Set out each resident's needs in an individual care plan developed and agreed with the resident.	
Action required: Keep each resident's care plan under formal review as required by the resident's changing needs or circumstances and no less frequent than at three-monthly intervals.	
Action required: Revise each resident's care plan, after consultation with him/her.	
Reference: Health Act, 2007 Regulation 8: Assessment and Care Plan Standard 10: Assessment Standard 11: The Resident's Care Plan Standard 17: Autonomy and Independence	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The evidence regarding consultation with resident and/or next-of-kin regarding the contents of care plan is shown by the signature of the person involved in each individual electronic care plan. All care plans are under formal review every three months or sooner where appropriate as evidenced in the electronic care file.	Completed

All care plans were revised after consultation with the resident/next of kin where possible and individualised sub-plans are in place for dealing with behaviours that may challenge others and/or preventing slips, trips or falls. See electronic care file for the residents involved.	

Theme: Person-centred care and support

Outcome 17: Residents' clothing and personal property and possessions

The person in charge is failing to comply with a regulatory requirement in the following respect:

An up-to-date list of residents' personal property and possessions had not been maintained.

Action required:

Maintain an up-to-date record of each resident's personal property that is signed by the resident.

Reference:

Health Act, 2007
Regulation 7: Residents' Personal Property and Possessions
Standard 4: Privacy and Dignity
Standard 17: Autonomy and Independence

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: All clothes and other personal items were reviewed, recorded and signed by a member of staff in Owen Riff. Residents able to sign have done so in the property book.	Completed

Theme: Workforce

Outcome 18: Suitable staffing

The person in charge is failing to comply with a regulatory requirement in the following respect:

The person in charge did not have sufficient control over staffing in the centre. A number of staff were working in the centre who were not employees of the provider. The staff rosters had not been maintained up to date for all hours worked by the person in charge and did not record all staff working in the centre.

Action required:

Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

Action required:

Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Reference:

Health Act, 2007
Regulation 16: Staffing
Standard 23: Staffing Levels and Qualifications

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The person in charge has full control over staff in the centre. Suitable and appropriate staffing is provided in the centre. This is based on appropriate skills mix, dependency levels of the residents, build environment and shift patterns. Shifts and rosters are planned and stored in the nurses office showing which staff members are on duty on any given day each week. An active recruitment process is in place to replace the activity coordinator who resigned on 19 October 2012.	Completed Completed

The provider is failing to comply with a regulatory requirement in the following respect:

Some staff files viewed did not contain sufficient evidence of mental and physical fitness and one file did not show evidence that Garda Síochána vetting had been obtained.

Action required:

Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 of the Regulations have been obtained in respect of each person.

Reference:

Health Act, 2007
Regulation 18: Recruitment
Standards 22: Recruitment

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The declaration regarding physical and mental fitness for staff working in the centre is in progress. We have requested that staff furnish us with this statement by mid-November.	November 2012

Outcome 9: Notification of incidents

The person in charge is failing to comply with a regulatory requirement in the following respect:
Notifications of an allegation of abuse had not been made to the Chief Inspector, as required.
Action required: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any allegation, suspected or confirmed abuse of any resident.
Reference: Health Act, 2007 Regulation 36: Notification of Incidents Standard 29: Management Systems

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's response: The notification was sent to the Acting Chief Inspector on 2 October 2012. The quarterly notification for the third quarter is sent as required before 31 October 2012.	Completed

Outcome 12: Safe and suitable premises

The provider is failing to comply with a regulatory requirement in the following respect:
Some parts of the centre were not maintained to an acceptable standard. There was no process in place for checking metal bedrails. Some bedrails were very loose and posed a risk to residents' safety. A written immediate action was issued in relation to this failing. Some areas had not been maintained in a clean and hygienic condition.

Adequate storage had not been provided for equipment. The temperature of the hot water supply to hand-wash basins was not adequately regulated.	
Action required: Maintain the equipment for use by residents or people who work at the designated centre in good working order.	
Action required: Keep all parts of the designated centre clean and suitably decorated.	
Action required: Ensure suitable provision for storage of equipment in the designated centre.	
Action required: Provide sufficient numbers of wash-hand basins fitted with a hot and cold water supply, which incorporates thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.	
Reference: Health Act, 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Maintenance work is in progress and will be completed over time once the registration is completed. Work has commenced on faults of an immediate nature. There is a bedpan washer in place and in use. The faulty bedpan washer will be removed and replaced in due course. A bedrail audit was completed and the record sent to the Authority on 10 October 2012. The premises had a 'spring clean' and routine cleaning is done as per Brindley Healthcare standard. Cleaning equipment for the catering area was removed from the laundry area to comply with HACCP guidelines. Relocation takes place as soon as the space where the faulty bedpan washer was located ready for use.	

A suitable space for the storage of equipment is identified. All equipment needing storage is now in an upstairs storage room. Hoist docking spaces are identified. The laundry will be relocated once Brindley Healthcare is registered. In the meantime, clean linen is removed from the laundry and stored in an upstairs linen room.	Completed Completed

Any comments the provider may wish to make:

Provider's response:

None received.

Provider's name: Catherine Cunningham
Date: 14 November 2012